



# Group Insurance Enrolment

- New Employee
- Reinstatement

500-2755 Lougheed Highway  
Port Coquitlam, BC, V3B 5Y9

Name of Employer

► This application is to be completed in BLUE INK. PLEASE PRINT. Please submit original application only — fax copies or photocopies cannot be accepted ◀

## Employee – Complete this section

Employee Last Name		First Name		Initial		Are you in Canada on a Work Visa?		Are you covered under your Provincial Health Plan?	
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Address		Apt./Unit #		Street		City		Postal Code	
Sex		Birth Date		Province of Residence		Language Preference			
<input type="checkbox"/> Male <input type="checkbox"/> Female		Month Day Year				<input type="checkbox"/> English <input type="checkbox"/> French			
						Marital Status		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
						<input type="checkbox"/> Common Law → *Date of Cohabitation _____			
(*Date of Cohabitation is mandatory if Common Law)									
Dep. No.	List Dependents			Sex	Birth Date			Relationship to You	
	Last Name	First Name		M/F	Month	Day	Year		
01	Spouse								
02	1st Child								
03	2nd Child								
04	3rd Child								
05	4th Child								

Do you have duplicate coverage under another Extended Health or Dental plan (e.g. your spouse's group plan)? If yes, provide:

Name of Insurance Company		Group Number	ID Number	<input type="checkbox"/> EHC	<input type="checkbox"/> Dental
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**Beneficiary Designation** (use full legal name – e.g. Mary Jane Doe, not Mrs. John Doe)  
I designate as revocable beneficiary in the event of my death:

	%
	%
Full Legal Name	Relationship Share of Proceeds

I agree to the conditions of the contract(s) between my employer and the insurer(s) and authorize my employer to deduct required contributions from my earnings. On behalf of myself and my dependents I authorize BBD Inc. and all insurers to exchange the information detailed in this application, and any other benefit related information contained in files regarding me or my dependents, either now or in the future, for the purposes of administration and/or management of the group insurance policies issued by the insurers. I understand that this original document and all other original documents pertaining to me and my dependents are the property of BBD Inc. and will be permanently retained by BBD Inc. as required by the insurers. I confirm that the information I have provided is true and complete.

**Trustee Designation** (complete only if beneficiary is under age 18)  
I appoint as revocable Trustee to receive any amount which may be due my beneficiary, while such beneficiary is a minor:

Full Legal Name

**X**  
Signature of Employee Date

## Partial Waiver

### Employee – Complete this section if applicable

I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan: (specify plan details below)

- For myself and my dependents .....  Extended Health Care  Dental Care
- For my dependents only .....  Extended Health Care  Dental Care

Name of Other Plan's Employer/Policyholder		Is this your spouse's group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, provide details)	I certify that I have been given an opportunity to participate in my employer's plan. Comparable coverage is currently provided to me and/or my dependents under another group plan. I understand that if I cease to be covered under this other plan, and I then wish to participate in my employer's plan, I will have to complete an application within 31 days of loss of coverage. If application for coverage is not made within 31 days I will be required to furnish, at my own expense, evidence of insurability satisfactory to the insurers, and all coverage is subject to their approval. On behalf of myself and my dependents I authorize BBD Inc. and all insurers to exchange the information detailed in this application, and any other benefit related information contained in files regarding me or my dependents, either now or in the future, for the purposes of administration and/or management of the group insurance policies issued by the insurers.
Name of Insurance Company			
Group Number	Identity Number		
			<b>X</b> Signature of Employee Date

## Employer – Complete this section

Employee's Earnings		Hours Per Week	Payroll Number (optional)		
\$ _____			Department Number	Employee Number	
<input type="checkbox"/> Annually <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Hourly					
Employee's Occupation		Class Code	I confirm that this employee is eligible to apply for coverage and that the information I have provided is true and complete.		
Date of Employment (New Employee)		Date of Rehire (Reinstatement)		Effective Date (for administrator use only)	
Month	Day	Year	Month	Day	Year
<b>X</b> Authorized Signature of Employer Date					